stand by our original classification of "relatively contraindicated" for injectable miconazole nitrate in view of the known and potentially serious toxicities and the unknown effects on the pregnant patient and the fetus.

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Condom Use, Not Barrier Method, To Prevent Heterosexual HIV Infection

TO THE EDITOR: George Rutherford, MD, and colleagues presented a comprehensive discussion of perinatal human immunodeficiency virus infection (HIV) in the July 1987 issue.[1] They made a statement that we wish to clarify because of the ambiguity of the term "barrier contraceptive."

"Regardless of other contraceptive methods used, they should use barrier methods of contraception—such as a condom or a condom plus a diaphragm with a nonoxynol-9-containing spermicide—during intercourse to diminish the chances both of transmitting HIV to their sexual partners and of being reinfected with it."[1]

Although there is some evidence that the condom decreases the rate of HIV infection,[2,3] there is no evidence to indicate that a diaphragm is protective. The diaphragm, used without a condom, will not prevent skin-to-vaginal mucosal contact and may not prevent contact with cervical secretions[4] or semen. The mode of heterosexual transmission from male to female or vice versa is not understood. It is not known if transmission from male to female is more efficient when virus contacts the vaginal squamous epithelium or endocervical glandular epithelium.

We should advise people that regardless of the contraceptive method used, a condom should be used with nonoxynol-9-containing spermicide, using correct technique.[5] If a couple chooses to use a diaphragm in addition to the condom and spermicide, they will have more effective contraception, but the combination may not protect them better against HIV infection.

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'Screening' and 'Routine' Testing

TO THE EDITOR: One article[1] and two Epitomes of Internal Medicine[2,3] in the September 1987 issue suggest that screening or "routine" testing is worthless in hospital admissions. Unfortunately, the authors fail to recognize the basic difference between screening and tests done at the time of a hospital admission. Blue Cross, Blue Shield and even the American College of Physicians have made the same mistake. It is time to correct this!

Screening is performed on healthy people to detect clinically inapparent disease; the purpose may be to minimize an insurance company's risk or to protect the public, as in screening blood donors for hepatitis or human immunodeficiency virus infection. The main goal of screening is not necessarily related to an individual's health and, admittedly, screening is unsuccessful in finding unrecognized disease.

Admission laboratory testing, by contrast, is performed on an unhealthy person at the time of a hospitalization in order to confirm a diagnosis, to rule out other diagnoses or complications and, most important, to establish a baseline of physiologic parameters so that the effects of our subsequent diagnostic, therapeutic or surgical interventions may be sensibly evaluated. Admission testing is not done to detect clinically unsuspected disease but, ironically, is more successful than screening in finding such because hospitalized patients are older and are more likely to have multiple conditions.

The lack of appreciation of the difference between screening and admission testing has led to the suggestion that admission testing be restricted in order to save money. It would not be inconceivable that Blue Cross/Blue Shield would next suggest that internists and other primary care physicians could save money by restricting a history to the "present illness" and confining physical examination to the suspect organ. Let us beware of such absurdities in both clinical and laboratory medicine.

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TO THE EDITOR: In the September 1987 issue Rucker and co-workers continue their assault on laboratory testing by arguing that screening electrolyte, blood urea nitrogen and glucose level determinations are not indicated when patients are admitted to hospital.[1] Two Epitomes[2,3] as well as an editorial[4] beatify this study by implying that it represents a significant advance in internal medicine, along with the authors' previous study of urinalysis.[5]

In fact, the study does not break new ground; rather, it sets up a straw man. Although the practice may, indeed, be prevalent, I know of no reputable authority that currently recommends screening of this type in patients admitted to hospital.[6] Any sensible physician will restrict the ordering of the cited tests to patients with findings such as those listed by the authors. One must assume that all six tests were obtained in their center in so many instances because the testing instrument or

the laboratory order form, or both, provided all automatically. With such an instrument available, providing all rather than those actually required may well be cost effective.[6]

Although the authors have undoubtedly documented an abuse of laboratory testing, it is questionable whether curbing such screening will substantially reduce laboratory costs. The marginal cost of large volume testing on automated equipment, if ordered in batches, is minimal. Indeed, unit costs are heavily volume-dependent and may increase significantly if fewer tests are ordered (the analogy to fares in public transit systems is apt). In my experience, far more expensive abuses include excessive repetition of testing and the ordering of large numbers—often redundant panels—of expensive exotic tests in pursuit of "zebras."

It is noteworthy that house officers (who actually request the tests) are ordering these screening panels in a higher proportion of patients admitted to the authors' medical center than they order urinalyses, despite the apparent greater yield of a urinalysis (I am pleased to note that the authors no longer refer to these as "routine").[1,5] Why are they doing so? Is it possible that their instruction is faulty? Or could it be that, to these young physicians, actions speak louder than words? Could Rucker and co-workers, their role models, be guilty of a "don't do as I do, do as I say" attitude?

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Phosphorus and Water

TO THE EDITOR: In the article "Emergent Management of Chemical Burns," extracted from *Audio-Digest Emergency Medicine,* in the September issue,[1] an erroneous statement regarding the chemical behavior of white phosporus was made. The article states, "White phosphorus is a material that basically ignites when exposed to water." White phosphorus is stored in water because it ignites easily in air.[2] Sodium metal, as the article states, reacts with water and is appropriately stored in oil.

If white phosphorus should come in contact with the skin, washing the area with a 2% solution of copper sulfate has been suggested, although the absorption of copper may be a complication.[3] Rather than covering the wound with oil, as recommended in the extract, the exposed area should be kept thoroughly moist with water until debridement or some other form of treatment can be instituted.

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More Insects in the Operating Room

TO THE EDITOR: A letter to the Editor, "Insects in the Operating Room," by Sherman and co-workers appeared in the September 1987 issue,[1] which arrived several days after the *American Medical News* arrived. The *American Medical News* documented Dr William Burman's interesting approach to dealing with insects in the operating room:[2] he bottled those he detected and sent them to the hospital administrator! Evidently, it was his belief that the insects were permanent residents in the hospital and had not come in with a patient.

Sherman and colleagues describe arresting the trespasser by the "surgical technique known as 'squashing.'" As a family physician I want to make sure that this technique is not entirely expropriated by surgical colleagues. After all it does seem to involve the "whole bug."

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